DEPARTMENT OF HEALTH AND H[illegible] N SERVICES
HEALTH CARE FINANCING ADMIN[illegible] RATION

FORM APPROVED
OMB NO. 0938-0214

MEDICARE QUESTIONNAIRE FOR DISABLED BENEFICIARIES

NAME	DATE OF BIRTH	MEDICARE NUMBER
MARY SMITH	5/10/1954	123456789A

INSTRUCTIONS: **This information will be read by a computer. Please print as shown below. Stay within the boxes. Use CAPITAL letters. Mark boxes with an X. USE BLACK OR BLUE INK.**

EXAMPLE A B C 1 2 3

SECTION A - INFORMATION ABOUT YOU

1) Are you getting any group health coverage from an employer for whom you **now** work or used to work (full or part-time)?

YES [X] NO [ ] **(If NO, STOP, go to Section B)**

2) How many employees, including yourself, work for the employer from whom you get group health benefits?

Don't Know [ ] 100 or more [X] Less than 100 [ ] (If less than 100, **STOP**, go to Section B)

3) What type of coverage do you have under your employer's health plan?

Worker only coverage [ ] Family coverage (husband/wife, other family member) [X]

Please print the name of the employer, and information about the employer group health plan in the spaces below:

EMPLOYER NAME
ACME DYNAMITE CO

ADDRESS
345 FARAWAY STREET

CITY SATURN STATE ME ZIP 55555

NAME OF GROUP HEALTH PLAN
GOOD HEALTH INC

ADDRESS
789 THIRD AVENUE

ADDRESS
SUITE 16

CITY MARS STATE ME ZIP 66666

GROUP IDENTIFICATION NUMBER

POLICY NUMBER

SECTION B - MORE INFORMATION ABOUT YOU

1) Are **YOU** getting Black Lung (Coal Miner's) Medical Benefits?

YES [ ] NO [X] If **YES**, Date Benefits Began: [ ][ ] - [ ][ ] - [ ][ ][ ][ ] (M M - D D - Y Y Y Y)

2) Are **YOU** now getting any medical services, related to an illness or injury which occurred on the job, for which **YOU** have or will file a workers' compensation claim?

YES [X] NO [ ] If **YES**, Date of Illness or Injury: 04 - 20 - 2000 (M M - D D - Y Y Y Y)

If **YES**, Insurer Name
EMPLOYERS ACCIDENT FUND

ADDRESS
911 MAIN STREET

ADDRESS

CITY BREEZY STATE ME ZIP 66661

EXPIRES 01-31-2002

SAMPLE

3) Are **YOU** now getting any treatment for an illness or injury for which another party could be held responsible or could be covered under no-fault, automobile, or liability insurance?

YES ☐ **NO** ☒ **If YES,** Date of Illness or Injury: M M – D D – Y Y Y Y

If **YES,** Insurer Name

ADDRESS

ADDRESS

CITY STATE ZIP

SECTION C - INFORMATION ABOUT YOUR HUSBAND/WIFE

1) On 6/1/2000 , will your husband/wife be working? **YES** ☒ **NO** ☐ **N/A** ☐

(If NO or N/A, STOP, sign bottom of form)

Husband/Wife's Name

FIRST: BILL Middle Initial: M

Husband/Wife's Social Security Number: 765-43-2222

LAST: SMITH

2) How many employees, including your husband/wife, work for your husband/wife's employer?

Don't know ☐ 100 or more ☐ less than 100 ☒ (If less than 100, **STOP,** please sign below)

3) Does your husband/wife have group health coverage through his/her employment? **YES** ☐ **NO** ☐

(If NO, STOP, please sign below)

What type of coverage does your husband/wife have under this health plan?

Worker only coverage ☐ Family coverage (husband/wife) ☐

Please provide the name of the employer, and information about the employer group health plan in the spaces below:

EMPLOYER NAME

ADDRESS

CITY STATE ZIP

NAME OF HEALTH PLAN

ADDRESS

ADDRESS

CITY STATE ZIP

GROUP IDENTIFICATION NUMBER

POLICY NUMBER

Your Signature Is Required

Mary Smith

AREA CODE PHONE NUMBER 333-876-1234

FORM HCFA 251 (4-00) **Expires 01-31-2002**

SAMPLE